wandering in an abnormal state in which he was first found by the police. He proved to have been a clerk of ability in a large establishment which he had suddenly left because a demand for more salary was refused, and had disappeared. Was it epilepsy?

Habit in Insanity. By A. B. RICHARDSON, M. D. Am. Journal of Insanity, April, 1887.

The three elements determining habitual discharge of nervous energy are (*a*) congenital disposition; (*b*) experience under external conditions; (*c*) inhibitory and directory power over the will. The latter two can be to a degree controlled. Disease especially, however, weakens the will, and the insane are more imitative than the sane. In the early stages of disease bad habits can be best modified for the better. Even delusions which are often very fixed may be removed or replaced by others less incurable, not by argument, but by environment and treatment. Fixed habits of treatment by physicians are responsible for many bad habits of patients. Habits of taking certain drugs, habits of filth and untidiness, laziness, destructiveness, and even homicidal propensities, may be greatly modified for the better by persevering adaptation of treatment to individual cases, remembering that "our nervous system grows to the modes in which it is exercised." Love of this adaptation and individual study is the best guarantee that a physician is growing in excellence. The writer has tried his method with great success in his own asylum. The patient must be always placed in a position most favorable to reassume sane habits.

Lecture on the Disorders of Language. By Professor BIANCHI, Naples. Alienist and Neurologist, April, 1887.

This article, translated by Dr. Joseph Workman, of Toronto, the well known and still vigorous octogenarian alienist, represents that the four elementary factors of speech (two sensory—hearing and seeing—and two motor—speaking and writing) which have been developed and inter-related in the evolution of speech, connect with functional extrinsication of diverse parts of the brain; writing and reading being of course much later ontogenetically and philogenetically than hearing and speaking. Hearing is located on the first temporal convolution and a part of the second; seeing words in the inferior parietal lobule; speaking in the foot of the left inferior frontal convolution, and writing at the foot of the left second frontal convolution. Each centre is situated within larger related areas, the motor in the wider field of arm or tongue-and jaw motions, and the sensory are specialized centres within the field of hearing and sight; and these special as well as the wider general centres are very closely related, so that a disease of one without an affection of others is rare. Each centre, too, is the focus of memory images. Thus one may hear but not know the meaning of words, as is the case with a child. This is the sensory aphasia of Wernicke, or the verbal deafness of Kussmaul, and is often associated with paraphasia. Lichtheim's view that the inner acoustic image, or internal diction, is indispensable to correct pronunciation is refuted by clinical facts. His theory that simple verbal deafness is due to lesion of the centripetal auditive paths before their entrance into the centre, it being sound, is opposed to that of Charcot and Kussmaul, that this may be due to lesion in the acoustic centre, while speaking, reading

and writing may be possible. In cases of pure verbal deafness the acoustic may be represented by the visual image. Bianchi dissents from Charcot's view that verbal deafness and verbal amnesia may have the same seat, but in the first case be destroyed and in the latter only superficially injured, and holds that amnesia may be due to interruption between the idea and acoustic centre, or due to enfeeblement of ideation. Verbal blindness is much less apt to be associated with psychic lesion than verbal deafness, although the latter often co-exists with intact ideative processes. If DeWatteville's view be correct that reading is possible only with true mnemonic and reproduction of acoustic images, then verbal blindness ought to be caused by interruption between the acoustic and visive centre. An interesting case of an aphasic is given who could not get the name "hat" from seeing it or even touching it, but just attained the word by taking the hat and putting it on his head with some force with both hands, and could pronounce the word "key" only in the act of turning a key. Whether this is sensory (Wernicke) or motor aphasia (G. Stewart) it is hard to tell, but the *post mortem* finding did not indicate disease of the word-centre.

On different Kinds of Aphasia, with special Reference to their Classification and ultimate Pathology. By H. C. BASTIAN. pp. 28. 1887.

Fourteen forms of defect in speech and writing are distinguished. The basis is anatomical, and the terms commissural aphasia, glosso- and cheiro-kinaesthetic centre may serve to suggest the chief novelties in this vexed field of classification. The paper contains interesting and new cases and diagrams.

De la Guérison de la Paralysie Générale, et de la Théorie des Pseudo-folies Paralytiques. BAILLARGER. Annales Médico-psychologiques, 1887, No. 1.

General paralysis is so universally held to be incurable that whenever a case of recovery has been reported it is at once set down, obvious and unique as the symptoms are, as a case of error in diagnosis. Even the case of recovery so minutely reported by Tuczek (in his Beiträge zur pathologischen Anatomie und zur Pathologie der Dementia paralytica) has been called an error of this sort. Baillarger, however, here reports a case of a man of thirty-nine who became prodigal in his expenses, excited, sleepless, with delusions of greatness as to his wealth, the number of his children, thought himself Pope and Emperor of Germany, and lost power to articulate certain sounds. About a year after he entered the asylum (1878) he had begun to recover, and at the intercession of his friends was granted leave of absence, the certificate of release stating, however, that he was enjoying a remission, that a fresh attack was certain, and that his intelligence was already greatly enfeebled. He quite recovered, and in 1882 resumed his post of business. Vision, however, was gradually impaired in one eye, and in 1884 symptoms of locomotor ataxia were fully developed. The author objects to the distinction between true general paralysis characterized by chronic periencephalitis, and pseudo-general paralysis due to simple circulatory derangements, and prefers to say that two distinct maladies have been confused under the term of general paralysis: one being characterized by diffuse delirium of greatness, hesitation of speech, and being quite distinct from general paralysis, the early stages of which it resembles, and being, unlike it, curable.